DOCUMENT RESUME

ED 303 717 CG 021 414

AUTHOR French, Laurence
TITLE The Victimization of the Homeless Mentally Ill.
PUB DATE Aug 88
NOTE 8p.; Paper presented at the Annual Meeting of the American Psychological Association (96th, Atlanta, GA, August 12-16, 1988).
PUB TYPE Reports - General (140) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Deinstitutionalization (of Disabled); *Health Needs; *Homeless People; Institutionalized Persons; *Mental Disorders; *Mental Health Programs; Psychiatric Services; Public Health; *Public Policy

ABSTRACT

An indication of the failure of the mental health system in this country is reflected in the increasingly visible homeless population, many of whom suffer from some form of untreated mental illness. Public policy priorities have shifted from proactive, treatment-oriented policies to reactive, punitive institutionalization. The deinstitutionalization movement of the past 20 years has come full circle. The deinstitutionalization movement was a well-intentioned, progressive movement supportive of community-based, least restrictive alternatives to overcrowded institutions. Twenty years later the need exists to reassess the latent consequences of this process, especially those attributes which contribute to the "victimization" of these unserved clients left with little or no treatment resources other than the criminal justice system. The first and most important step in ameliorating these problems and building a responsible clinical network is to change the primary treatment criterion from the "least restrictive" to the clinically specific "most therapeutic" environment. While the ideal situation is to begin to implement a viable "child find" and subsequent early intervention and prevention programs, an effective method of treating the current "lost legion" of deinstitutionalized and never-served homeless mentally ill persons is needed. In the final analysis viable clinical and legal improvements can only come about when these changes are mandated through public policy and supported through the allocation of adequate resources. (ABL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED303717

U.S. DEPARTMENT OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

THE VICTIMIZATION OF THE HOMELESS MENTALLY ILL

Laurence French, PhD Division #9

An indication of the failure of the mental health system in this country is reflected in the increasingly visible homeless population -- many of whom suffer from some form of untreated mental illness. This paper explores the shift in United States public policy priorities from proactive (treatment-oriented) to reactive (punitive) institutionalization. Ironically, the deinstitutionalization movement, especially as it relates to mental and developmental treatment facilities, was a well-intended, progressive movement supportive of community-based, least restrictive alternatives to overcrowded institutions. The eventual reality, however, is a far cry from this intended mandate. Twenty years later we find the need to reassess the latent consequences of this process, especially those attributes which contribute to the "victimization" of these unserved clients left with little or no treatment resources other than the criminal justice system.

The deinstitutionalization movement of the past 20 years has come full circle and with harmful repercussions for many mentally ill people. One third of the one to three million homeless people in the United States are estimated to be in need of mental health care. Many of the mentally disabled street people are part of the "lost legion" of the 1.5 million deinstitutionalized chronically mentally ill -- those who have managed to bypass the community mental health network. In addition, there are countless numbers of never-treated homeless who have been denied access to either public treatment institutions or community-based facilities. Uncoded, untreated, poorly socialized, and often undereducated, a growing number of alienated marginal people are becoming homeless with a disproportionate representation among youth (run aways/throw aways) and the elderly. Together these groups represent a substantial untreated population that lives on the lowest rung of American society. Thus their mental and social situation helps fuel a self-fulfilling prophecy whereby these people become victimized by their situation. And without viable clinical interventions this population is at high risk either as victims of crimes or offenders. As offenders their actions often involve both survival techniques (theft, unlawful entry, solicitation, sexual midconduct...) and behaviors secondary to their clinical condition. Paradoxically, jails and prisons (a growth industry in the U. S. today) have come to replace the mental hospitals and state schools which once housed these individuals. However, incarceration carries the additional stigma of being "bad" as well as "mad".

The history of this process extends back to the post World War II era at which time our society witnessed a

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Laurence French
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)"

marked increase in both our correctional and treatment institutions. Unable to adequately treat their inmates health care facilities, notably state and federal (veterans) institutions, became crowded warehouses for disturbed clients. Clearly, over-crowded conditions and harsh management techniques served to exacerbate the very conditions for which these clients were institutionalized in the first place. Moreover, those subjected to these deplorable condtions were often from the lower and working classes.

Social psychologists noted these trends in the 1950s and 1960s. Hollingshead and Redlich (1953; 1954) associated the quality of mental health care with social class: the higher a client's social class the better access will they have to quality clinical treatment. Demographic studies also linked chronic mental illness with poor and/or transient communities. It was from these communities that the severely mentally ill client was most likely to be admitted to a custodial mental health facility. Dunham (1953) accounted for this process with his "tolerance and drift" theory. According to this theory, a marginal person, notably one who does not receive adequate services for his or her mental or emotional condition, will likely drift into a community or subculture which is tolerant of their behaviors thus accounting for the disproportionate representation of these people in certain communities. These processes reflect what happens when a society places its focus on the reactive instead of the proactive end of the care continuum.

At the onset many mental illnesses are treatable but left unattended and reinforced by a subculture of "outsiders" (fellow marginals coexisting in a near-group structure) they rapidly deteriorate and eventually fall into the ranks of the chronically mentally ill -- those most difficult to treat (Becker, 1968; Linsky, 1970; Stonequist, 1937; Suttles, 1968; Wolfgang & Ferricuti, 1967; Yablonsky, 1962). Yet when society becomes intolerant of these people, it often reacts in a punitive fashion resulting in a greater representation of "marginals" within our penal system. We are currently witnessing this process among the homeless mentally ill in the United States today. This type of societal reaction/formation constitutes "blaming the victim" and not a viable treatment response (Arvanties, 1988).

A Failed Network

In many respects deinstitutionalization was and continues to be a flawed movement. Much of its failure can be attributed to the failure of both the community mental health network and the case management system to process and treat the socially marginal, often impoverished, client. Hence, while the number of institutionalized mentally ill and mentally

retarded people has decreased markedly in the 1970s and 1980s, jails and prisons have become overcrowed. Ironically, in many instances the criminal justice system has come to replace the mental health system as the primary care provider for homeless mentally ill people. Thus, these clients are now easy targets of victimization both on the streets and within the criminal justice system. The mass media constantly reminds the public of seemingly senseless killings and deaths among the "grate society".

The most likely community "treatment" for the homeless mentally ill person constitutes nothing more than residence at a shelter. Some communities, in an effort to rid itself of this "problem", have been known to provide discharged clients with one-way, out-of-state bus ticket. Community shelters are commonly referred to as "three hots and a cot", while the bus ticket tactic is known as "Greyhound therapy". Such temporary solutions facilitate both the tolerance and drift and the labeling processes. Homeless shelters are generally located in the slum or bowery district of a city thereby forcing the homeless into the most marginal and unstable sections of society -- those most prone toward violence and victimization.

Given this scenario we can better see the reasons why the public has little tolerance for the homeless mentally ill. Shrouded in ignorance and fear, society has made this problem a low fiscal priority. What attention is given to this problem usually is directed at the untreated mentally ill person who is potentially assaultive. The National Institute of Justice posits the legal perspective as such: "The presence of street people may give the impression that no one cares about a neighborhood, thus signaling to real criminals that they can enter the area and commit offenses with impunity. Port Authority police in New York and New Jersey found that by creating the impression that law and order had broken down, homeless inhabitants of bus and train stations attracted a deviant fringe which victimized not only the homeless but also the general public. Even the most docile street people generate repulsion and fear among many residents, shoppers, and commuters. The prospect of being accosted by a drunken, disoriented, or hostile panhandler can be as frightening for many people as the prospect of meeting an actual robber. As a result, parents who wish to take their children to the park, or elderly people who want to shop at a nearby store, may aviod these locations - in effect losing the right to make use of public areas which their taxes and purchases support (Finn, 1988)."

With this official public policy attitude toward the marginal homeless we can see how they carry the stigma of being potential criminals. With the homeless mentally ill clinical interventions usually are stop-gap measures, such as involuntary emergency hospitalization from three to ten

days. Repeated episodes generally result in criminal charges and incarceration. Clearly, incarceration is not a reasonable alternative to clinical treatment. Jails merely exacerbate the mentally disabled person's already low-stress tolerance while prisons further increase the chances that the mentally disturbed person will be exploited and victimized.

Characteristics of the Homeless Mentally Ill

Mental illness, whether it be chronic or acute, clouds judgement and therefore competency during episodes. Mentally ill people generally have a lower tolerance of stress, a factor that can exacerbate both the onset and intensity of mental illness. Sexual acting out, repetitious behaviors, impulsiveness, and swings in affect all make the untreated mentally ill person more prone toward engaging in deviant acts such as impersonal sex, polydrug abuse, and theft, especailly during clinical episodes. Other problems include seizure activity, hepatitis, pica, and poor gross and fine motor coordination. Chronically mentally ill persons also usually manifest cognitive problems such as memory deficits and short attention span. This, in turn, effects their ability to learn appropriate social behaviors or to comply with normative expectations. Consequently, untreated homeless mentally ill persons are likely to be a-social and to retreat further into their own intrapsychic worlds. Devoid of a functional reality they become easy victims of prey.

Current research indicates a link between mental illness and other never-treated members of the street subculture -- runaway children (especially the abused), Vietnam veterans, drug addicts, and skidrow alcoholics. The strongest link lies between the Post-Traumatic Stress Disorder and self medication (substance abuse). Apparently these mental health problems (P-TSD and substance abuse), left unattended, lead to neurochemical changes in the brain similar to those associated with people afflicted with organic aggressive disorders (Organic Personality Syndrome, Intermittent Explosive Disorder...). It is precisely these features, paranoid ideations and intense impulsive aggressive outbursts, that often bring these untreated individuals to the attention of the criminal justice system either as victims or as offenders (Langeuin, 1987; Tarter, 1984).

Fischer and Breakey (1986) developed a typology of homeless people which provides insight into the degree of mental illness prevalent -- if any -- among these classes of marginal members of society.

1. The Chronically Mentally Ill. This subgroup is made up of mentally disabled people who in some cases have been

recently deinstitutionalized but in others have been in and out of the ambulatory mental health system without even having had a significant history of hospitalization. Some of these homeless people fall into the group described as the "young chronics", who are mostly men, but are younger that the traditionally homeless population.

2. Street People. "Bag ladies", "grate men", or "street people", whose bizarre appearance make them particularly visible. These people, both male and female, apparently elect to live relatively isolated from others to the extent that they are reputed to shun shelters in favor of choosing their own places to sleep and eat, e.g., in parks, in doorways, in vacant buildings, under bridges, and in subways. It appears that the prevalence of mental disorders may be high among street people.

3. Chronic Alcoholic. Alcohol abuse occurs in all groups of homeless people. There is a hard core, however, of skid-row chronic, deteriorated alcoholics whose life-style centers around the procurement and consumption of alcohol.

4. The Situationally Distressed. It is likely that this fourth subgroup contains relatively few mentally ill people. It includes many drawn from the "new poor", who have recently become unemployed, evicted, or ejected from home following a domestic quarrel, or are traveling in search of work. Interpersonal vulnerabilities resulting from personality disorders, impaired intellectual capactiy, and/or substance abuse may have played a part in leading them into their current misfortune (Fischer & Breakey, 1986: 11-12).

A large proportion of the four subgroups of homeless persons presented above involve marginal members of society most who fall outside the mental health network. A substantial proportion of deinstitutionalized people have spilled over into a number of these categories -- the chronically mentally ill, street people, and chronic alcoholics. The never-treated mentally ill, on the other hand, are represented in all four categories with the last category indicating the potential for early intervention.

Toward A Responsive Clinical Network

The first and most important step in ameliorating these problems and building a responsive clinical network is to change the primary treatment criterion from the "least restrictive" to the clinically specific, "most therapeutic" environment. And while the ideal situation is to begin to implement a viable "child find" and subsequent early intervention and prevention programs -- we still need an effective method of treating the current "lost legion" of deinstitutionalized and never-served homeless mentally ill

persons. This solution requires a joint effort between the criminal justice and the mental health and developmental services systems (Finn & Sullivan, 1988).

A model for service is provided by the Mental Health Association of Montgomery County, Maryland. The first and most important step in this model is to provide a strong commitment to adequate resources for the chronically mentally ill homeless population. These resources include shelters and personnel. The clinical steps include: (1) developing a trust relationship with the clients, (2) educating the client as to the resources available, (3) providing an escort service to ensure that the client gets to therapy, and (4) a strong referral and advocacy support network. As would be expected the first step is both the most significant in this process as well as being the most difficult to initiate and maintain (Billig & Levinson, 1987).

In the final analysis, however, viable clinical and legal improvements can only come about when these changes are mandated through public policy and supported through the allocation of adequate resources. Clearly, our society needs to change its focus from a reactive to a proactive treatment perspective. If not, we merely continue to fuel a self-fulfilling prophecy which enhances costly correctional strategies at the expense of clinical treatment.

References

Arvanties, R. 1988. The Impact of State Mental Hospital Deinstitutionalization on Commitments for Incompetency to Stand Trial, Criminology, 26:307-319.

Becker, H. 1968. Outsiders. New York: Free Press.

Billig, N. & Levinson, C. 1987. Homelessness and Care Management in Montgomery County, Maryland, Psychosocial Rehabilitation Journal, XI:59-66.

Finn, P. 1988. Street People, National Institute of Justice (Crime File). Rockville, MD: U. S. Department of Justice (U. S. GPO; 1988-195-750).

Finn, P., & Sullivan, M. 1988. Emergency Response to the Homeless, National Institute of Justice Report, No. 209 (May/June).

Fischer, P., & Breakey, W. 1986. Homelessness and Mental Health, International Journal of Mental Health, 14: 6-41.

Langeuin, R., et. al., 1987. Brain Damage, Diagnosis, and Substance Abuse among Violent Offenders, Behavioral

Sciences & the Law, 5:77-94.

Linsky, A. 1970. Who Shall be Excluded. Social Psychiatry, 5:106-171.

Stonequist, E. 1937. The Marginal Man, New York: Russell & Russell.

Suttles, G. 1968. The Social Order of the Slum, Chicago: University of Chicago Press.

Tarter, R., & Alterman, A. 1984. Neuropsychology Deficits in Alcoholics, Journal of Studies on Alcohol, 45:1-9.

Wolfgang, M., & Ferracute, F. 1967. The Subculture of Violence, London: Travistick.

Yablonsky, L. 1962. The Violent Gang, New York: Macmillam Company.